

NAME: _____

DATE OF BIRTH: _____

TODAY'S DATE: _____

PATIENT HISTORY UPDATE
REVIEW OF SYSTEMS

Since your last annual exam at this office, have you developed any new medical problems?

Since your last annual exam at this office, have you had any surgery?

Since your last annual exam at this office, has anybody in your family developed any new medical or surgical problems?

Since your last annual exam at this office, has your use of alcohol or tobacco changed?

Since your last annual exam at this office, have you developed any of the following symptoms?

1. weight gain, weight loss, fever, fatigue.
2. vision changes, change in glasses or contacts.
3. mouth, nose, ear or sinus problems.
4. chest pain, shortness of breath, rapid heart beat, or chest pain with exercise.
5. chronic cough, asthma, or wheezing.
6. abdominal pain, nausea, vomiting, diarrhea, constipation, or blood in stools.
7. loss of urine, urinating frequently, painful urination, or blood in urine.
8. muscle weakness, muscle pains, restricted movement.
9. skin rashes or ulcers, breast pain, breast masses.
10. dizziness, seizures, numbness, or movement problems.
11. sadness, crying easily, excessive irritability, or exaggerated anxiety.
12. hot flushes, night sweats, heat or cold intolerance.
13. easy bruising, bleeding from gums, or swollen lymph nodes.
14. NEW ALLERGIES TO MEDICATIONS.